Family Foot Care

Dr. Jeffrey Idol Dr. Ruth Devadas Dr. Azuka Olele

Patient Registration

Name: (First) _____ (Middle) _____ (Last) _____

Reason for visit: _____

Pharmacy Name: _____ Location (city): _____

Date of Birth: _____/_____/_____ Male Female

Marital Status: Married Single Widowed Divorced

Primary Doctor: _____ Referring Provider: _____

State Issued Picture ID must be brought to the appointment. If the patient is a minor, the parent's Picture ID must be obtained.

Address: _____ _____Apt #: _____

City: _____ State:_____ Zip Code: _____

Home phone: _____ Cell phone: _____

Email address: _____

Contacts

Employer Name: _____ Phone Number: _____

Occupation: _____

Emergency Contact

Name: _____ Relation: _____

Phone number: _____

Spouse/Parent/Legal Guardian Information

Name: _____ _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relation: _____ DOB: _____/_____/_____

Employer: _____

_____ _____

Signature **Date**

Medical History

AIDS/HIV	**YES**	**NO**	**HIGH BLOOD PRESSURE**	**YES**	**NO**
ANEMIA	**YES**	**NO**	**HEMOPHILIA**	**YES**	**NO**
ARTIFICIAL HEART VALVES	**YES**	**NO**	**LIVER DISEASE (hepatitis/cirrhosis)**	**YES**	**NO**
ARTIFICIAL JOINTS	**YES**	**NO**	**NEUROPATHY**	**YES**	**NO**
ASTHMA	**YES**	**NO**	**OSTEOARTHRITIS**	**YES**	**NO**
AUTOIMMUNE DISEASE	**YES**	**NO**	**PACEMAKER**	**YES**	**NO**
BACK PROBLEMS	**YES**	**NO**	**PHLEBITIS**	**YES**	**NO**
BLEEDING DISORDER	**YES**	**NO**	**POOR CIRCULATION**	**YES**	**NO**
CANCER	**YES**	**NO**	**RHEUMATOID ARTHRITIS**	**YES**	**NO**
CHOLESTEROL PROBLEMS	**YES**	**NO**	**RHEUMATIC FEVER**	**YES**	**NO**
DIABETES: TYPE I	**YES**	**NO**	**SEIZURES**	**YES**	**NO**
DIABETES: Type II	**YES**	**NO**	**STOMACH ULCERS**	**YES**	**NO**
EMPHYSEMA/COPD	**YES**	**NO**	**STROKE**	**YES**	**NO**
GASTRIC REFLUX	**YES**	**NO**	**THYROID DISEASE**	**YES**	**NO**
GOUT	**YES**	**NO**	**TUBERCULOSIS**	**YES**	**NO**
HEART ATTACK	**YES**	**NO**	**HEART DISEASE**	**YES**	**NO**
			VARICOSE VEINS	**YES**	**NO**

Please list any medical condition(s) not mentioned above:

_____

_____

Are you currently experiencing, or have experienced in the past, any of the following:

Ankle pain	**Athlete's Foot**	**Corns/Callouses**	**Bunions**	**Flat Feet**
Heel pain	**Ingrown nails**	**Plantar Warts**	**Numbness in feet or legs**	

Allergies

ADHESIVE TAPE	**YES**	**NO**	**DEMEROL**	**YES**	**NO**
LOCAL ANESTHETICS	**YES**	**NO**	**ANTI-COAGULANTS**	**YES**	**NO**
IODINE	**YES**	**NO**	**SEAFOODS**	**YES**	**NO**
ASPIRIN	**YES**	**NO**	**NOVOCAINE**	**YES**	**NO**
SULFA DRUGS	**YES**	**NO**	**CODEINE**	**YES**	**NO**
PENICILLIN	**YES**	**NO**	**OTHER: _____**		

_____ _____

Signature **Date**

Physicians

Additional doctors who are managing the patient's care:

Primary Care Physician: _____

Endocrinologist: _____

Other: _____

SURGERIES:

_____

MEDICATIONS: (List all medications taken.)

_____

FAMILY HISTORY: Check any that apply and indicate MOTHER (M) or FATHER (F).

HEART DISEASE: ___ M ___ F DIABETES: ___ M ___ F CANCER: ___ M ___F

HYPERTENSION: ___ M ___ F STROKE: ___ M ___ F

<u>SOCIAL HISTORY</u>

Tobacco use: NEVER CURRENT USER QUIT FOR _____

Illicit drug use: NEVER USED CURRENT USER HISTORY OF USE _____

IV Drug Use: NEVER USED CURRENT USER HISTORY OF USE _____

Are you under the care of Pain Management? YES NO

Alcohol use: YES NO If yes, how often? _____

If patient is diabetic, how often do they check their blood sugars? _____

Last HA1c? _____ What is the normal range? _____

_____ _____

Signature **Date**

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, AND TREATMENT CONSENT.

Health and accident insurance policies are a contractual arrangement between an insurance carrier and the insured. It is the responsibility of the insured to verify eligibility for health care benefits. Possession of a medical insurance member ID card is **NOT** a guarantee of coverage. As a courtesy to you, we will gladly submit your medical bills to your insurance carrier.

1. **Primary Insurance:** I request that payment of authorized benefits be made on my behalf to Family Foot Care for services furnished to me by Family Foot Care. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. Family Foot Care accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service.
2. **Secondary Insurance:** I understand that if other health insurance is indicated my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Family Foot Care if possible or otherwise to me, at which time I would forward all payments to Family Foot Care.
3. **Release of Information:** Family Foot Care may disclose all or any part of my medical record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract with Family Foot Care for reimbursement for services rendered and (2) any health care provider for continued patient care. Family Foot Care may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.
4. **Non-Covered Services:** I understand that Family Foot Care contracts with health insurance plans. Accordingly, the undersigned accepts full financial responsibility for all items and services, which are determined by the health care insurance plan as non-covered services.
5. **Financial Agreement:** I agree that in return for the services provided to me by Family Foot Care I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Family Foot Care for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits on any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Family Foot Care. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.
6. **Divorced Parents:** We do NOT second party bill. The parent/legal guardian bringing the child to our facility will be responsible for required co-payments, deductibles etc. at the time of service.
7. **Privacy Plan:** I agree that I have been given the opportunity to read and receive a copy of Family Foot Care Notice of Privacy Practices.
8. **NOTICE:** ANYONE UNDER THE AGE OF 18 WILL NOT BE SEEN WITHOUT A PARENT OR GUARDIAN PRESENT UNLESS YOU ARE AN EMANCIPATED MINOR.
9. **TREATMENT CONSENT:** By signing below I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me, as the doctor deems necessary. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____

SIGNATURE of Patient, Guardian or Representative DATE

_____

Please PRINT name Relationship to Patient